

PROGRESS OF MEDICAL SCIENCE.

MEDICINE.

UNDER THE CHARGE OF

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On the Cultivation of Typhoid Bacilli from Rose-spots.—RICHARDSON (*The Philadelphia Medical Journal*, March 3, 1900, p. 514) points out the scientific and diagnostic value of the rose-spots in typhoid fever as determined by recent research. That the rose-spots are due to a metastasis of the typhoid bacilli from the intestine to the skin has been frequently demonstrated since the discovery of the typhoid bacillus by Eberth. In investigating this point, however, many negative results had been obtained.

Neufeld has recently reviewed the subject and gives some remarkable results obtained by himself. He found that the efforts to cultivate the typhoid bacillus from the rose-spots had hitherto been so often negative that they had little value either from a scientific or from a diagnostic stand-point. Neufeld's results, however, have been extraordinary in that he cultivated the typhoid bacillus in thirteen out of fourteen cases. He attributes his good results to the fact that he as quickly as possible transferred the drop of blood from the rose-spot to a tube of nutrient bouillon. In this way he was able to dilute the bactericidal substances of the blood so thoroughly and quickly that they no longer destroyed the typhoid bacilli, as they do when cultures are taken in the ordinary way. To the lack of observance of this method of technique Neufeld attributed the frequent negative results of previous workers.

Neufeld compared the date of the earliest appearance of the Widal reaction with the earliest day of the disease on which he had obtained the typhoid bacillus from the rose-spots. This was done in eight cases, and he found that in seven out of the eight cases the diagnosis made from the rose-spots was, on an average, six days ahead of that made by the Widal test, whereas in only one case was the Widal reaction obtained first.

Thomson says: "From a review of these etiological factors we may conclude that the age of the patients, the absence of sufficient light in their surroundings, and the presence of rickets are the most important influences in determining the onset of the disease; likewise that anything which temporarily or permanently lowers the vitality may predispose to its occurrence."

SURGERY.

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A Contribution to the Surgery of Perforated Gastric Ulcer.—MITCHELL (*British Medical Journal*, March 10, 1900) has collected thirteen cases of gastric ulcer that have recently been operated upon. The statistical value is due to the fact that successful and unsuccessful cases are alike recorded, and the result—thirteen cases, with six recoveries—must be regarded as eminently satisfactory. The first case operated on by the author was nearly hopeless, as it was sixty hours after perforation. In another the wall of the stomach was so rotten that it tore to the extent of one and one-half inches, and a large mass of tissue, apparently malignant, occupied the anterior wall of the organ at some distance from the ulcer.

The symptoms of the average case are given as follows: A patient, male or female, with or without a history of previous gastric symptoms, is suddenly seized with violent abdominal pain, immediately followed by profound shock and collapse, and perhaps by vomiting. The pain, which may at first have been localized, rapidly becomes general. The abdomen becomes intensely tender, with its muscles hard and rigid. On percussion there is a tympanitic note all over; possibly there is a diminished area of hepatic dullness, especially in front. The bowels are inactive. The patient is cold and livid, with subnormal temperature, has a quick, feeble pulse, thoracic respiration, anxious expression, and suffers from intense thirst. Soon a period of repose commences, when the sufferer feels distinctly easier, the pulse improves a little as the initial shock passes off; the abdominal retraction is replaced by slight distention, and liver dullness becomes markedly diminished. In a short time, however, the pain returns, tenderness increases, the temperature rises, and the patient exhibits all the signs of general septic peritonitis; or in the more fortunate cases the peritonitis is localized by adhesions, and an abscess forms. Thus the characteristic symptoms of per-